New Jersey Department of Health and Senior Services
Division of Aging and Community Services

NOTIFICATION FROM LONG-TERM CARE FACILITY OF ADMISSION OR TERMINATION OF A MEDICAID PATIENT

I. PATIENT INFORMATION

1. Name: _____ (Last) _____ (First)
2. Social Security No.: ___ - ___ - ___
3. HSP (Medicaid) Case No.: _____ - ___ Confirmed By: _____ (CWA) ☐ Medicaid Only ☐ SSI
4. Authorized By: _____ **LTCFO** Date of Birth: ___ / ___ / ___
5. Sex: ☐ Female ☐ Male

II. PROVIDER INFORMATION

1. Provider Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___
2. LTCF Name: _____ 5. Long Term Care Field Office _____
3. Address: _____ LTCFO Street Address: _____
4. City, State, Zip: _____ City, State, Zip: _____

III. ADMISSION INFORMATION

1. Admission Date: ___ / ___ / ___
2. Admitted to Room Number: _____ Bed Number: _____
3. Admitted from: ☐ Community/Boarding Home ☐ Medicare to Medicaid ☐ Psychiatric Hospital
   ☐ Private to Medicaid - anticipated Medicaid effective date: ___ / ___ / ___
   ☐ Hospital ☐ Other LTCF ☐ Other (specify): _____
4. Name of Hospital/LTCF: _____ Admission Date: ___ / ___ / ___
   Address: _____
5. If admitted from Hospital/LTCF, give the name/address of previous residence (Hospital Name and Address or Home Address):
   _____

IV. TERMINATION INFORMATION

1. Discharge Date: ___ / ___ / ___
2. Discharged to: ☐ Own Home (check one): ☐ With Medicaid Services or ☐ Without Medicaid Services
   ☐ Relative's Home (check one): ☐ With Medicaid Services or ☐ Without Medicaid Services
   ☐ Assisted Living (Name/County): _____
   ☐ Other LTCF (Name/County): _____
   ☐ Other (specify): _____
   Telephone Number of Discharge Site _____
3. Death (Date): ___ / ___ / ___ ☐ In LTCF ☐ In Hospital

V. CERTIFICATION

The facility certifies that the patient will reside only in those areas of the facility which are certified for participation in the New Jersey Medicaid Program at the level of care authorized for this patient by the New Jersey Medicaid Program. The facility also certifies that upon discharge to a hospital, the patient's room/bed will be reserved for the full period of time covered by the New Jersey Medicaid Bed Reserve Policy.

This form completed by:

Name: _____

Title: _____ Date: _____

VI. CWA USE ONLY

Medicaid Effective Date: ___ / ___ / ___

☐ Medicaid ONLY (PA-3L Attached)
☐ SSI Only (PA-3L Required, Contact DHSS)
☐ Not Eligible
☐ Transcript Requested - Date: ___ / ___ / ___

COUNTY WELFARE OFFICE _____
Street Address: _____
City and Zip: _____

Remarks: _____

Name of Case Worker: _____ Date: _____